

Report to the Congress • March 2009

As required by the Congress, the Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations each March. The March 2009 report includes payment policy recommendations for nine payment systems: hospital inpatient, hospital outpatient, physicians, ambulatory surgical center, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities, and long-term care hospitals. It also reviews the status of the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional FFS Medicare and the plans that provide prescription drug coverage.

In addition, the report includes MedPAC recommendations on public reporting of physicians' financial relationships with pharmaceutical and device manufacturers and health care providers, and on reforming Medicare's hospice payment system.

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

Hospitals

- The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2010 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.
- The Congress should reduce the indirect medical education adjustment (IME) in 2010 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the IME adjustment should be used to fund a quality incentive payment program.

Physicians and Ambulatory Surgical Centers

- The Congress should update payments for physician services in 2010 by 1.1 percent.
- The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.
- The Congress should direct the Secretary to increase the equipment use standard for expensive imaging machines from 25 to 45 hours per week. This change should redistribute RVUs from expensive imaging to other physician services.
- The Congress should increase payments for ambulatory surgical centers (ASC) services in calendar year 2010 by 0.6 percent. In addition, the Congress should require ASCs to submit to the Secretary cost data and quality data that will allow for an effective evaluation of the adequacy of ASC payment rates.

Dialysis Services

- The Congress should maintain current law and update the composite rate in calendar year 2010 by 1 percent.

Skilled Nursing Facility Services

- The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2010.

- The Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system by: adding a separate nontherapy ancillary (NTA) component, replacing the therapy component with one that establishes payments based on predicted patient care needs, and adopting an outlier policy. (June 2008)
- The Secretary should direct SNFs to report more accurate diagnostic and service-use information by requiring that: claims include detailed diagnosis information and dates of service, services furnished since admission to the SNF be recorded separately in the patient assessment, and SNFs report their nursing costs in the Medicare cost report. (June 2008)
- The Congress should establish a quality incentive payment policy for SNFs in Medicare and to improve quality measurement for SNFs, the Secretary should: add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute care quality measures; revise the pain, pressure ulcer, and delirium measures currently reported on CMS's Nursing Home Compare website; and require SNFs to conduct patient assessments at admission and discharge. (March 2008)

Home Health Services

- The Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels.
- The Congress should direct the Secretary to re-base rates for home health care services in 2011 to reflect the average cost of providing care.
- The Congress should direct the Secretary to assess payment measures that protect the quality of care and ensure incentives for the efficient delivery of home health care. The study should include alternative payment strategies such as blended payments and risk corridors and outcome-based quality incentives.

Inpatient Rehabilitation Facilities

- The update to the payment rates for inpatient rehabilitation services should be eliminated for fiscal year 2010.

Long-Term Care Hospitals

- The Secretary should update payment rates for long-term care hospitals for fiscal year 2010 by the projected rate of increase in the rehabilitation, psychiatric and long-term care hospital (RPL) market basket index less the Commission's adjustment for productivity growth.

STATUS OF MEDICARE ADVANTAGE PROGRAM

About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008. All beneficiaries have access to an MA plan in 2009, with an average of 34 plans available in each county.

In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package are 102 percent of FFS in 2009, compared with 101 percent of FFS in 2008. As an exception, HMOs continue to bid below FFS, bidding 98 percent of FFS in 2009. In 2009, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009, compared with 113 percent in 2008.

MA plans provide enhanced benefits to enrollees, but, except for HMOs, the enhanced benefits are financed entirely by the Medicare program and by beneficiaries—and at a high cost. For example, each dollar's worth of enhanced benefits in PFFS plans costs the Medicare program more than \$3.00.

Quality is not uniform among MA plans or plan types. High-quality plans tend to be established HMOs; in contrast, plans that are new in the MA program have lower performance on many measures.

The Commission has not changed its standing policy regarding MA payments, and reiterated its 2005 recommendations in the March 2009 report:

Recommendations on Medicare Advantage Payments

- The Congress should: Eliminate the stabilization fund for regional PPOs. Remove the effect of payments for indirect medical education from the MA plan benchmarks. Set the benchmarks that CMS uses to evaluate MA plan bids at 100 percent of FFS costs. Pay-for-performance should apply in MA to reward plans that provide higher quality care. Clarify that regional plans should submit bids that are standardized for the region's MA-eligible population.
- The Secretary should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans.

STATUS OF PART D PROGRAM

As of January 2008, 90 percent of Medicare beneficiaries received some form of drug coverage. Fifty-eight percent of all Medicare beneficiaries enrolled in Part D plans; 32 percent had drug coverage at least as generous as Part D through employer-sponsored plans or other sources. Twenty-one percent of Medicare beneficiaries received Part D's extra help with premiums and cost sharing (called the low-income subsidy or LIS). An estimated 2.6 million beneficiaries eligible for the LIS were not enrolled to receive it.

In 2009, the number of stand-alone prescription drug plan (PDP) options declined by 7 percent, but beneficiaries can still choose among a median of 49 PDPs. For 2009, Part D premiums are significantly higher than in 2008. If enrollees stayed in the same plan, they saw premiums rise by an average of \$6 to nearly \$31 per month (24 percent).

For 2009, fewer premium-free PDPs will be available to enrollees who receive the LIS: 308 plans qualified, compared with 495 in 2008. CMS estimated that it needed to reassign about 1.6 million LIS enrollees to new plans for individuals to avoid paying some of the premium: 1.2 million to a plan offered by a different sponsor and 0.5 million to a plan offered by the same sponsor.

PUBLIC REPORTING OF PHYSICIAN FINANCIAL RELATIONSHIPS

Requiring manufacturers to publicly report their financial relationships with physicians and other health care organizations should have several important benefits. It could discourage physicians from accepting gifts or payments that violate professional guidelines. It would help reporters and researchers explore whether manufacturers and physicians are complying with voluntary industry and professional standards. In addition, payers could use this information to examine whether physicians' practice patterns are influenced by their relationships with industry.

In addition to financial relationships with drug and device manufacturers, physicians may also have financial ties to health care facilities. Although physician ownership of facilities may improve access and convenience for patients, evidence suggests that physician-owned hospitals are associated with a higher volume of services within a market. Nevertheless, it is difficult for payers and researchers to obtain ownership information. The report recommends hospitals and other health care entities that bill Medicare be required to disclose the amount and degree of physician ownership of the facility.

Recommendations on Public Reporting of Physician Financial Relationships

- The Congress should require all manufacturers and distributors of drugs, biologicals, medical devices, and medical supplies (and their subsidiaries) to report to the Secretary their financial relationships with: physicians, physician groups, and other prescribers; pharmacies and pharmacists; health plans, pharmacy benefit managers, and their employees; hospitals and medical schools; organizations that sponsor continuing medical education; patient organizations; and professional organizations.

- The Congress should direct the Secretary to post the information submitted by manufacturers on a public website in a format that is searchable by: manufacturer; recipient's name, location, and specialty (if applicable); type of payment; name of the related drug or device (if applicable); and year.
- The Congress should require manufacturers and distributors of drugs to report to the Secretary the following information about drug samples: each recipient's name and business address; the name, dosage, and number of units of each sample; and the date of distribution. The Secretary should make this information available through data use agreements.
- The Congress should require all hospitals and other entities that bill Medicare for services to annually report the ownership share of each physician who directly or indirectly owns an interest in the entity (excluding publicly traded corporations). The Secretary should post this information on a searchable public website.
- The Congress should require the Secretary to submit a report, based on the Disclosure of Financial Relationships Report, of the types and prevalence of financial arrangements between hospitals and physicians.

REFORMING THE HOSPICE BENEFIT

The hospice benefit provides a substantial contribution to end-of-life care for Medicare beneficiaries. However, MedPAC research finds that Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We also find that certain hospices have questionable practice patterns (e.g., very long stays, financial relationships with nursing homes) that justify additional oversight. Finally, we find that the Medicare program lacks data vital to the effective management of the benefit.

Recommendations on Reforming the Hospice Benefit

- The Congress should direct the Secretary to change the Medicare payment system for hospice to: have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases; include a relatively higher payment for the costs associated with patient death at the end of the episode; and implement the payment system changes in 2013, with a brief transitional period. These payment system changes should be implemented in a budget neutral manner in the first year.
- The Congress should direct the Secretary to: require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place, require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.
- The Secretary should direct the Office of Inspector General to investigate: the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice, differences in patterns of nursing home referrals to hospice, the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.
- The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.